

A Critical Access Hospital  
Case Study



IDAHO  
FLEX  
PROGRAM

# EVALUATION '08

BOUNDARY COMMUNITY HOSPITAL, BONNERS FERRY, IDAHO





# IDAHO FLEX PROGRAM

## Boundary Community Hospital Bonners Ferry, Idaho

### EVALUATION '08

*Is the Medicare Rural Hospital Flexibility (Flex) Program and small rural hospitals' conversion to Critical Access Hospital (CAH) status improving the quality of care and the performance of small rural hospitals, enhancing local emergency medical services, and fostering network development? A case study highlighting Boundary Community Hospital, Bonners Ferry, Idaho, was conducted as part of Idaho's Medicare Rural Hospital Flexibility (Flex) Program and its program evaluation activities to examine and report on these questions.*

## CASE STUDY OBJECTIVES AND METHODS

The Boundary Community Hospital case study was completed to identify community, hospital, and other health care related changes and outcomes that have occurred due to Boundary Community Hospital's conversion to Critical Access Hospital (CAH) status and its involvement in the Flex Program. It was also completed to identify needs and issues for program planning purposes. To accomplish this, the following occurred:

- Local health services and community background information was collected from June – July 2008 on Bonners Ferry, Idaho.
- Interviews of hospital staff, hospital board members, and local emergency medical services (EMS) personnel were conducted in Bonners Ferry, Idaho, in July 2008.
- A survey of health care providers (physicians, physician assistants, nurse practitioners, nurse anesthetists, and clinical social workers/counselors) working in Boundary Community Hospital was conducted in July 2008. The survey response rate was 77.8 percent.
- A community focus group was conducted in Bonners Ferry, Idaho, in July 2008. There were seven participants.
- Twenty-five individuals from the hospital service area participated in the case study.

77.8%  
response rate!

The Idaho Department of Health and Welfare, Office of Rural Health and Primary Care, administers the Flex Program in Idaho and was the sponsor of the case study. Rural Health Solutions, St. Paul, Minnesota, conducted the case study and prepared this report.

## BONNERS FERRY, IDAHO AND THE SURROUNDING AREA

Bonnors Ferry is located in north-central Idaho near the Canadian, Washington, and Montana borders. It is the county seat of Boundary County and has been identified by tourists as Idaho's "friendliest city." Boundary County has an area of 1,277 square miles that consists of mountain, lake, forest, and agricultural terrain. Seventy-five percent of the land is state or federally owned. Traditionally a logging and agricultural area, Bonners Ferry is now attracting retirees and nature enthusiasts to its outdoor recreation area and gateway to Canada. The largest employers in Bonners Ferry are Boundary Community Hospital, Boundary Trading Company, Elk Mountain Farms, and Idaho Education Services.

In 2007, the estimated population of Boundary County was 10,872 and Bonners Ferry was 2,723; this is a 13 percent increase in the county's population when compared to 1997 (9,633). Bonners Ferry lies along Highway 95 about 32 miles north of Sandpoint, Idaho, (where the next nearest hospital is located) 78 miles north of Coeur d'Alene, Idaho, where the nearest tertiary hospital is located.

### Bonnors Ferry

population in 1997 = 9,633

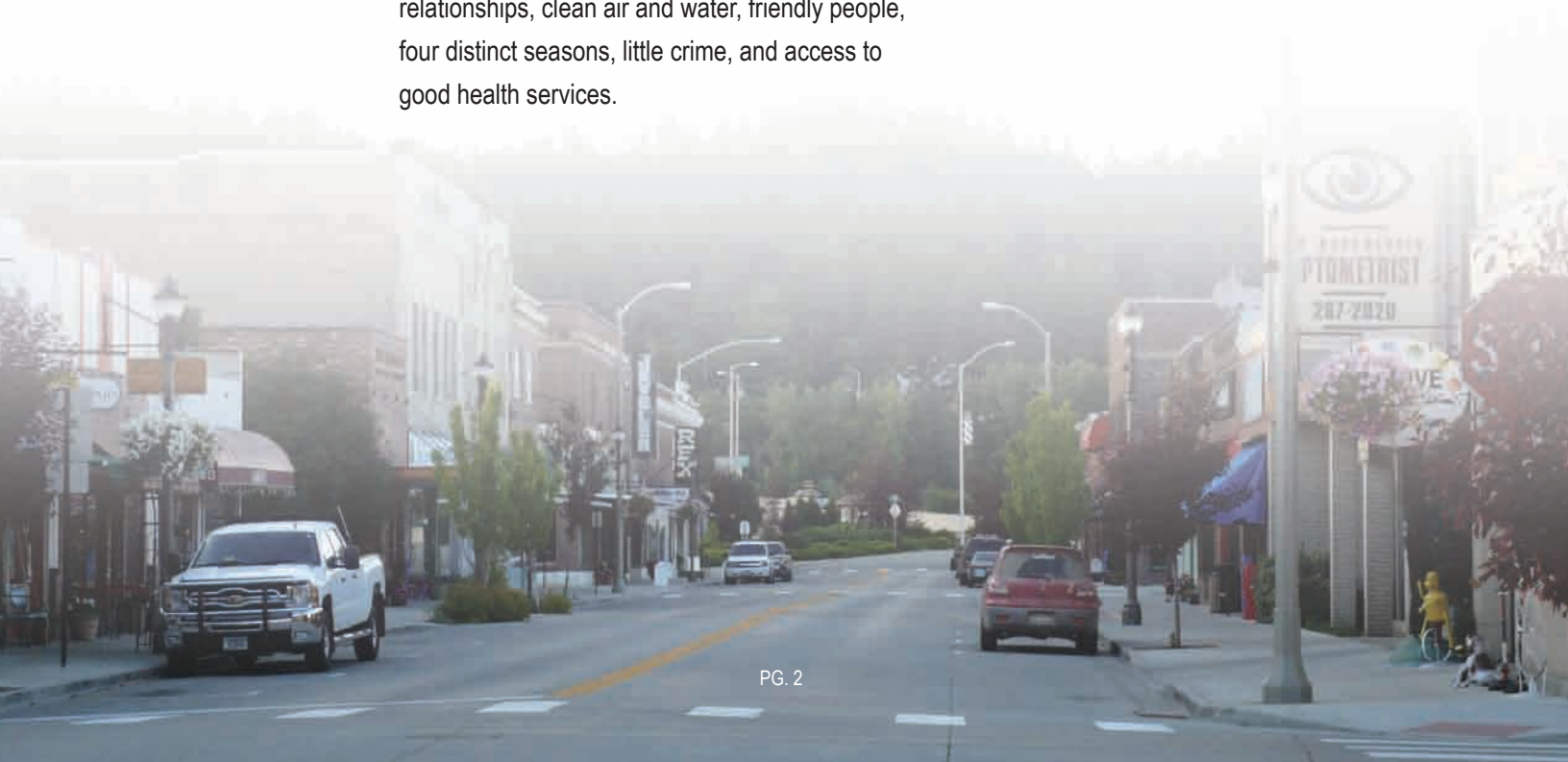
population in 2007 = 10,872



*"It's a quiet and lovely place to just be."*

— Case Study Participant

When asked, "What makes Bonners Ferry a healthy place to live?", case study participants characterized the community as having: a slow-paced lifestyle, easy access to outdoor recreational activities, less stress, a strong sense of community, collegial relationships, clean air and water, friendly people, four distinct seasons, little crime, and access to good health services.





## BONNERS FERRY *cont...*

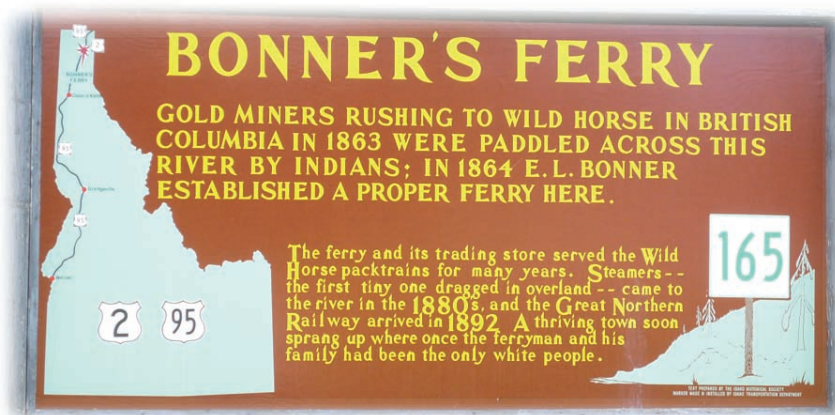
When asked, “What makes Bonners Ferry an unhealthy place to live?”, case study participants reported: water quality, poverty, lack of mental health services, low wages, lack of health insurance, need for many to work multiple jobs to make a living, a large number of motor vehicle accidents involving wild life, hazardous occupations such as logging and mining, lack of public transportation, a population that lacks health related education/knowledge, distance to specialty health services during time-sensitive events (e.g., strokes), and prescription drug abuse. Community members also discussed the changing demographics, in particular the number of retirees that are moving to Bonners Ferry as compared to the declining younger population. Community members stated the incoming retirees have needs and expectations that cannot typically be met by a remote rural community that relies on volunteerism.

*“I didn’t understand  
small when I first  
moved here but  
now I do.”*

— Case Study  
Participant

*“If you don’t  
drive, you  
don’t go  
anywhere.”*

— Case Study  
Participant



## BOUNDARY COMMUNITY HOSPITAL

Boundary Community Hospital, a 20-bed CAH, converted to CAH status April 8, 1999, making it the 1st hospital to convert in Idaho and the 46th to convert in the U.S.<sup>1</sup> The hospital offers emergency care, general surgery, a full diagnostic imaging department, rehabilitation services, and a variety of other outpatient services. Attached to the hospital is a 36-bed long-term care facility. The hospital works closely with Kaniksu Health Services, a Federally Qualified Health Center (FQHC) located across the street from the hospital, as well as other local physician clinics. The hospital administrator, who also serves as the hospital's chief financial officer, has been working in the hospital for 8 years and the Chief Nursing Officer/Quality Improvement Coordinator 25 years. There are 16 physicians (2 full-time, 7 part-time, and 7 visiting/consulting) and 70 full-time equivalent employees or 180 employees working at the hospital.

Boundary Community Hospital's service area is approximately 1,277 square miles and includes the communities of Bonners Ferry, Moyie Springs, and Naples. This service area population can be characterized as being older, less racially diverse, poorer, and less likely to have a high school diploma or college degree when compared to the population of Idaho. The hospital's 2007 average daily census for inpatients was two acute care and four swing-bed patients per day and the hospital had 3,244 emergency room visits and 17,231 outpatient visits that same year.



### Boundary Community Hospital's MISSION STATEMENT:

*"We service our community by promoting health and providing high quality healthcare with compassion and respect."*

***"We have a volunteer EMS service that is second to none."***

**— Case Study Participant**

Ambulance services for the area are provided by Boundary Volunteer Ambulance Service, Inc., a private non-profit. It provides advanced life support services through 31 staff, including: 22 EMT-Basic (11 of which are active on the squad), 6 EMT-Advanced (3 of which are active on the squad), and six ambulance drivers (3 of which are active on the squad).<sup>2</sup> The ambulance service has one part-time paid staff and the remaining staff are volunteers. The ambulance service responded to 457 calls in 2007. Run volume has reportedly increased over the past five years.<sup>3</sup>

<sup>1</sup>. As of April 2008, there are 26 CAHs in Idaho and 1289 in the U.S. Source: Flex Program Monitoring Team.

<sup>2</sup>. EMT indicates Emergency Medical Technician.

<sup>3</sup>. As reported by Boundary Volunteer Ambulance Service, Inc.

# impact

## OF THE FLEX PROGRAM

*“CAH conversion meant do or die for our hospital.”*

— Case Study Participant

The Medicare Rural Hospital Flexibility Program was created as part of the federal Balanced Budget Act of 1997. Its goals are to: 1) Convert small rural hospitals to CAH status; 2) Support CAHs in maintaining and improving access to rural health care services; 3) Develop rural health networks to increase health care efficiency and effectiveness and to advance the other Flex Program goals; 4) Integrate EMS into the continuum of health care services; and 5) Improve the quality of rural health care. Boundary Community Hospital was selected for an impact analysis using a case study approach in order to examine program outcomes and the impact the Flex Program has on local communities. Data were obtained from the Idaho Department of Health and Welfare, Office of Rural Health and Primary Care, State EMS Bureau, and the national Flex Monitoring Team, as well as case study participants. Case study participants were asked questions related to each of the Flex Program goals, focusing on outcomes, accomplishments, needs, and on-going issues. Below is a status report for each goal, including: goal status, indicators for success, and indicators of on-going needs and issues. Although many of the indicators cannot be directly and/or purely attributed to the activities of the Idaho Flex Program, case study participants reported that without the Flex Program, each accomplishment would have been difficult, delayed, and/or not pursued without the Idaho Flex Program.

## goal: **#1** Convert Hospitals to CAH Status

**Status:** ACCOMPLISHED

### **Indicators of Outcomes Achieved:**

- Boundary Community Hospital converted to CAH status April 8, 1999, making it the first hospital to convert in the state.
- It took the hospital approximately 16 months to explore the CAH conversion option, complete a financial feasibility study, work with Flex Program supported staff at the Idaho Hospital Association and the Office of Rural Health and Primary Care, to prepare for and complete the CAH application process, and to be surveyed and licensed as a CAH.
- Hospital staff report that CAH conversion allowed the hospital to continue operating; however, because the state's fiscal intermediary was not prepared to make payments to CAHs, Boundary Community Hospital had significantly increased financial issues during the conversion process.

*“We received tremendous support from our State Office of Rural Health and the Idaho Hospital Association.”*

— Case Study Participant

- The hospital had a swing-bed program prior to CAH conversion; however, they did not use it. During the CAH conversion process and through the support of the Flex Program, they learned about swing-bed use and how to market the services to the community. These changes have improved access to the continuum of health services available locally, in particular access to intermediate/ swing-bed and long term care services.
- All but one health care provider surveyed reported they are aware the hospital is a CAH.
- One health care provider surveyed reportedly was involved in the CAH conversion process and “strongly supported” the hospital’s conversion to CAH status.
- All community members expressed their support for the hospital and its value in maintaining access to health services, in particular given the distance and type of roads traveled to the next closest hospital.
- Comments/information by case study participants related to the CAH conversion process include:

*“I am really proud of this hospital. The majority of people are forward thinking.”*

— Case Study Participant



- *“We received calls from them weekly [State Office of Rural Health and Idaho Hospital Association]. They were like our cheerleaders.”*
- *“Financially, they [the fiscal intermediary] were not ready for us. Because of this, we did not get paid and we ran into major financial issues. It took a long time to recover from that.”*
- *“Instead of remaining a stagnant hospital, we were given the opportunity [through CAH status] to move forward to best meet our community’s needs.”*
- *“The surveyors were extremely helpful throughout the conversion process.”*
- *“This community would die without a hospital.”*
- *“CAH has helped keep the doors open and inpatient services viable in the community.”*

## goal: #2 Support CAHs in Maintaining and Improving Access to Health Care Services

### Status: OUTCOMES ACHIEVED/ON-GOING NEEDS



#### **Indicators of Outcomes Achieved:**

- The hospital improved its financial viability by improving hospital operations. This was accomplished by eliminating its home health services (services were already available in the community through another provider), closing its physician clinic and re-opening it as an FQHC, and decreasing its number of nursing home beds from 48 to 36.
- The hospital took the lead in establishing an FQHC in the community.
- The hospital added physicians, staff in various departments, ultrasound, a 16-slice CT (computer tomographic) scanner, mobile MRI services, 24-hours per day emergency room coverage (physicians were on-call in the past), and specialty and surgical services.



- The hospital upgraded and expanded radiology and laboratory services and equipment, matured its performance improvement and quality improvement programs, and made significant changes to its billing department to improve its efficiency and effectiveness.
- The hospital physical plant has been updated/renovated and expanded with plans for additional expansion.
- Hospital inpatient and outpatient volumes have increased.
- The hospital has been able to increase wages which has decreased staff turnover.
- The hospital's average days in accounts receivable (A/R) has improved. Prior to conversion, the average number of days in A/R was over 200 days as compared to 55 days, their current average.
- The hospital implemented a variety of payment plans, incentives, and changes in its billing processes to improve patients' satisfaction with the billing experience and to decrease uncompensated care.
- The hospital implemented a new maintenance schedule, upgraded its mopping system, and changed to more ecologically sensitive products. These changes have decreased maintenance staff time for cleaning and decreased the amount of harmful waste released into the environment. The hospital is also in the process of purchasing new laundry equipment which will have a positive impact on maintenance costs, staffing, and job satisfaction.

*"It's just a little  
community  
hospital where  
things are  
so cool."*

— Case Study  
Participant

*"We [the hospital]  
have grown stronger  
through this program,  
stronger in the things  
that are most  
important to us."*

— Case Study  
Participant



- CareLearning.com, a program initially sponsored by the Flex Program, is used by hospital staff for training (e.g., EMTALA). Through this program, the hospital reports they have increased staffs' computer literacy, decreased training costs, improved compliance with training requirements, and increased the amount of training available to staff.
- The hospital has used Flex Program funding to support its staff training library and hospital strategic planning activities. It has also used funding to explore new ways of operating. Reportedly, this has allowed the hospital to test things they wouldn't have been able to do/risk without the Flex Program funding support.

- Hospital staff state they have attended the Flex Program funded Northwest Regional CAH conference and report, “it’s an excellent meeting and one of the best in the area.”
- The hospital has developed grow-your-own training programs for staff which has decreased recruitment time for some positions.
- Hospital staff report that management changes have resulted in better care for patients and a better working environment in the hospital.
- Community members report their perceptions of the hospital have improved and they speak very favorably of the long-term care facility and its staff.
- Community members report the hospital’s community outreach activities have increased and improved, in particular the annual health fair and work in the schools.
- All health care providers report their overall opinion of the hospital and the care provided as “very good” (57.14 percent) or “good” (42.86 percent).
- 42.9 percent of health care providers surveyed report they are engaged in community health promotion/disease prevention activities. Community education/presentations, health screenings, and the annual health fair were the most commonly identified activities.
- Health care providers report the greatest accomplishments of the hospital in the past five years as increasing radiology and surgical services, improvements in the hospital’s physical plant, enhancements/modernization of diagnostic imaging and lab services, and the weekly visits by consulting specialists.
- Comments/information by case study participants related to maintaining/sustaining access to health care services include:



- *“The Flex Program has provided opportunities for collaboration.”*
- *“There are lots of things we couldn’t do without Flex Program support. It is all positives and no negatives.”*
- *“CAH designation and support, a change in hospital leadership, and additional physicians and specialists are they keys to our success.”*
- *“We used to run on antiquated equipment. Now we have sophisticated diagnostic and lab equipment.”*
- *“The Flex Program has helped us to better serve our community.”*
- *“The business office was a mess but we have come a long way to change the way we do business.”*



### **Indicators of On-going Needs/Issues:**

- The hospital's financial performance has improved since CAH conversion; however, the hospital continues to struggle financially.
- The hospital is recruiting a scrub technician, emergency room physician, and respiratory therapist.
- Hospital staff report the Flex Program should make changes to the funding made available to CAH through the Flex Program by re-defining the areas/activities that can be supported.
- The hospital needs assistance with planning for and addressing issues related to physical plant, staff training, and equipment challenges.
- The hospital reports needing assistance with determining the services that it should provide locally.
- The hospital in Sandpoint, Idaho, is considering conversion to CAH status.
- The hospital would like to expand the services available locally but does not have space.
- Hospital staff report there continues to be issues with people using the emergency room to meet their primary care needs and staff have been unable to resolve this issue.
- Community members report the greatest issues impacting access to services include access to mental health services, transportation, and the lack of community knowledge about the services available at the local hospital and FQHC.
- Health care providers report they have limited access to continuing education opportunities.
- Health care providers report the greatest issues facing the hospital's patient population as access to specialty care, uninsured/underinsured, and substance abuse. Other noted issues include: access to mental health services, awareness of preventative health, maintaining an adequate number of physicians, need to advance surgery services, aging population, and disease severity.
- Health care providers report the greatest issues facing the hospital as: poor reimbursement, lack of capital for changes to the hospital's physical plant, community's lack of awareness about the hospital's financial needs to remain viable, hospital staff recruitment and retention, keeping equipment up-to-date, remoteness of the community, and lack of community support.
- Health care providers report that funding for the hospital should be directed to equipment upgrades, subsidized care for the uninsured/underinsured, and creating linkages between the hospital, EMS, and mental health services.
- Comments by case study participants related to maintaining/sustaining access to health care services include:



— *"We had \$500,000 in uncompensated care last year. We cannot deal with that year after year."*

— *"Seventy percent of the hospital's patients are insured through Medicare and Medicaid. Many of these people believe they don't have to pay their deductible."*

— *"Some local physicians are not taking new Medicare patients."*

— *"We need a better education facility for employees."*

— *"People don't have insurance so they use the emergency room."*

— *"What's an FQHC? I thought I had to have insurance to use the clinic."*





## goal: #3 Develop Rural Health Networks

### Status: OUTCOMES ACHIEVED/ON-GOING NEEDS

#### ***Indicators of Outcomes Achieved:***

- The hospital is a member of the North Idaho Rural Health Consortium. The network is working to address issues related to HIT connectivity, recruitment and retention of staff, reimbursement issues, and physician integration.
- As part of the North Idaho Rural Health Consortium the hospital is coordinating with other hospitals in the development of its electronic medical record. In addition, member hospitals' department leadership meet quarterly to share best practices, network, and problem solve.
- Hospital staff report increased networking with other small rural hospitals particularly with those in Northwestern Idaho.
- The hospital is networking with Kootenai Medical Center, Coeur d'Alene, Idaho, to provide tele-psychology services.
- EMS and hospital staff report there has been an increase in the integration of staff training opportunities which has resulted in community networking and improved community relations.

#### ***Indicators of On-going Needs/Issues:***

- Opportunities exist to coordinate the strategic plans of the three regional networks in the state with the state's rural health plan and its overall Flex Program planning activities.

# goal: Integrate EMS into the Continuum #4 of Rural Health Care Services

## Status: OUTCOMES ACHIEVED/ON-GOING NEEDS

### Indicators of Outcomes Achieved:

- EMS and hospital staff report local organizations coordinate for staff training purposes.
- EMS staff report they attend an annual EMS conference held in Grangeville, Idaho. This reportedly is a good training and networking opportunity.
- EMS and hospital staff report they have good working relations, including having EMS personnel that work in the emergency room as needed, the hospital emergency department director who serves as the medical director on the local ambulance, and a hospital nurse who provides EMS training.
- A local EMS assessment was completed by the Flex Program to identify community EMS needs that should be addressed. Case study participants report the assessment provided a list of local EMS goals to work towards.
- The following local activities were completed in response to EMS assessment recommendations:

- Formalized the roles and responsibilities of EMS administrators.
- Developed an education and training needs assessment.
- Integrated training and education with the ongoing recruitment and retention program.
- Developed and implemented written air medical dispatch protocol by adopting the state protocol.
- Hired a part-time EMS administrator (as of June 2008).
- Formalized the relationship between the medical director, EMS agency, and the hospital.
- Replaced an outdated playback recorder.
- Installed additional phone lines in the dispatch center.
- Developed a written job description for the EMS agency physician medical director by using the state's template.



*"They [EMS] work hard at making sure everyone is trained and educated. And we [hospital and EMS] work well together."*

— Case Study Participant

*"Local organizations have explored a fully-paid*

*service [EMS] and they realize the numbers are small and it's just not financially feasible to operate that way right now."*

— Case Study Participant

- The following local activities are in-process/being completed in response to EMS assessment recommendations:
  - *Developing and implementing a formal, long-range recruitment and retention program. The focus has been on ambulance drivers and adding fire fighters to the squad.*
  - *Continuing cooperative efforts for construction of a new EMS agency facility.*
  - *Formalizing efforts to jointly sponsor public education and information programs (CPR sponsored to date).*
  - *Utilizing the agency medical director to develop formal triage and transfer guidelines and destination determination protocols.*
  - *Developing and implementing a formal, comprehensive quality improvement program with support from the medical director.*
  - *Utilizing the hospital quality improvement department as a resource for developing the tools to maintain patient confidentiality as part of the quality improvement process.*
- Comments/information by case study participants related to EMS:
  - *“I don’t know who their [EMS staff] employers are, but they’re great.”*
  - *“That you can get people to leave their jobs to care for other people as volunteers is amazing.”*
  - *“We [hospital and EMS] work really well together.”*
  - *“EMTs help out in the emergency room all the time when there are multiple patients and CPR needs to be continued.”*

### **Indicators of On-going Needs/Issues:**

- Hospital and EMS staff report that blackout areas still exist in the most remote areas.
- The area does not have enhanced 911 services.
- Hospital staff report that limited run volume has an impact on EMS staffs' skill level.
- Health care providers report there are EMS issues related to the transfer of patients with urgent medical needs.
- Community members report that people in the community are unaware that the local EMS agency is a volunteer service.
- EMS staff report that recruitment of volunteer EMTs is an issue, primarily because of the aging population and most community members cannot be on-call during the day.



- EMS staff report that the community's increasing obesity rate impacts staff recruitment and retention and the squad's need for more costly, specialized equipment.
- EMS and local fire fighters report that some models of new cars are more dangerous to work with during the extrication process. This is due to the cars' higher voltage systems which require additional training and knowledge to work safely.
- Community members report a general need for community, city council, and commissioner education regarding the roles, responsibilities, and value of local EMS.
- Local EMS is exploring opportunities to conduct joint EMS training between the ambulance services in Sandpoint, Idaho, and Bonners Ferry.
- A local EMS assessment was completed by the Flex Program to identify community EMS needs that should be addressed. The following local activities have not been completed or have realized limited progress as recommended in the assessment:

*"Our population is not only aging but they have gained a lot of weight."*

— Case Study Participant

*"We need to be prepared to provide a broad array of services [EMS] in many environments."*

— Case Study Participant

- *EMS members have discussed but have been unable to develop and implement criteria for squad membership, including an on-call schedule.*
- *A new EMS administrator has been hired; however, training for this staff has not been provided.*
- *Although pursued and discussed, an EMS advisory council has not been developed and implemented due to a lack of buy-in from community stakeholders.*
- *Written patient destination protocols have not been developed and implemented.*
- *EMS staff have investigated and discussed the need for an emergency management dispatch (EMD) system, including EMD certification for dispatchers; however, it has not been implemented due to resistance from other community stakeholders.*
- *Local EMS staff have discussed the need to support public education programs targeted at increasing the public's awareness of available emergency resources within the community. Given the lack of EMS resources, they have not been able to meet this need.*
- *The medical director has not participated in the one-day NHTSA/ACEP medical director's course primarily because the medical director is new to the EMS agency.<sup>4</sup>*
- *Although the EMS agency has begun collecting run data electronically, data have not been collected for the purposes of enhancing public health and safety.*

- Comments/information by case study participants related to EMS needs/issues include:
  - *"Their [EMS] only limitation is they cannot do complicated transports."*
  - *"Not many people truly understand an all volunteer ambulance service."*
  - *"First responders are providing medical care to patients that they are not trained to provide."*
  - *"EMS recruitment is tough because community wages are low and people cannot afford to leave their jobs to volunteer."*

<sup>4</sup>. NHTSA – National Highway Traffic Safety Administrations and ACEP – American College of Emergency Physicians.

# goal: #5 Improve the Quality of Rural Health Care

## Status: OUTCOMES ACHIEVED/ON-GOING NEEDS

### Indicators of Outcomes Achieved:

- Physicians and hospital staff report the hospital has quality improvement initiatives in place to improve quality of care.
- At the time of CAH conversion, the hospital's nursing home was moving towards decertification because of deficiencies, since that time they have made significant improvements which have resulted in two deficiency-free surveys.
- The hospital has provided quality improvement training to its board members and supports the purchase of quality improvement related literature for all of its board members.
- The hospital board receives monthly updates and reports on quality indicators and projects as well as patient satisfaction survey data.
- The hospital won a quality improvement award from BlueCross BlueShield of Idaho for being the "Best Small Hospital" as well as other quality improvement awards.
- The hospital was the first in the state to develop a pneumococcal immunization registry that is connected with physician offices and the attached long-term care unit. Currently, there are approximately 550 people in the registry with 85 percent compliance. Initially, 30 percent of long-term care patients were immunized and today 100 percent of patients are immunized (except those that refuse).
- The hospital was the first in the state to develop a diabetic protocol.
- The hospital submits data to Hospital Compare for two indicators, pneumonia and acute myocardial infarction.
- The hospital has adopted a scorecard which has increased physician participation in quality initiatives.
- The attached long-term care unit has implemented a flexible schedule and a "person-centered care" approach for a more "homelike" atmosphere for residents.
- Comments/information by case study participants related to improving quality of care include:
  - "The staff now talk about changes to the system and processes, not about people and issues."
  - "Some departments may have three quality initiatives going on at once."



*"We try and make our quality initiatives mean something."*

— Case Study Participant

*"The philosophy of the hospital [regarding quality improvement] has totally changed."*

— Case Study Participant

*“The leadership team is not into finger pointing. They just want to talk about how to change the process.”*

— Case Study Participant

- *“We all live here and we’re all stakeholders in the quality of care provided, so I want it to be good.”*
- *“Before, all of our quality improvement activities were about risk and how to avoid risk. Now, we are looking at quality and how to provide the highest quality of care to patients.”*
- *“We [hospital] had strong departments but they didn’t play well together. We needed to change all of that and we didn’t stop until things changed.”*
- *“The hospital encourages staff to go out and network with others. That is where they learn the most.”*
- *“I think most of our indicators have improved over time.”*
- *“We never used to have medical staff asking what can they do [regarding quality improvement]. Now they ask, so what can we do?”*
- *“Boundary Community Hospital is a great place to work with good patient care and quality improvement program activities in place.”*

### **Indicators of On-going Needs/Issues:**

- Hospital staff report there is a community need for drug awareness education, in particular related to prescription drugs.
- Hospital patient satisfaction data indicate there is additional need for senior education and outreach in the community.
- Hospital staff report the hospital continues to struggle with meeting the needs of the uninsured and underinsured.
- The community has a grass roots movement aimed at health improvement that is evolving and may serve as an opportunity to improve quality of care.
- Comments/information by case study participants related to quality improvement needs include:
  - *“It is easy to fall back into old habits and lose quality momentum. Particularly when we lose key staff.”*



# conclusions:

*This case study highlights many of the local level successes and challenges of Boundary Community Hospital and the Idaho Flex Program. It is clear that the hospital converted to CAH status, expanded access to services, made enhancements to services, implemented initiatives to improve hospital operations and quality, and is working to meet community needs. It is also evident that the hospital, local EMS, and the community continue to require support in order to further advance the goals of the Flex Program and to better meet the needs of its aging population. Other needs to be addressed relate to physical plant limitations, staff training, hospital EMS marketing/community knowledge of the services available, and financial concerns.*

ADDITIONAL INFORMATION:

If you have questions about the Idaho Flex Program or the Office of Rural Health and Primary Care, please contact Mary Sheridan, Director at **208/334-0669** or via e-mail at [ruralhealth@dhw.idaho.gov](mailto:ruralhealth@dhw.idaho.gov).

You can find the Office of Rural Health and Primary Care on the Web at

[www.ruralhealth.dhw.idaho.gov](http://www.ruralhealth.dhw.idaho.gov)



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